Franklin Square
Hospital Center

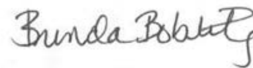
MedStar Health

Dear Doctor:

Thank you for your interest in one or more of the hospitals affiliated with the Baltimore Division of MedStar Health. Please complete the enclosed Application Request Form and return it to my attention at the address listed above at your earliest convenience. This office will review the information and will, if necessary, contact you should it need additional information.

If you meet the medical staff's general standards set forth in the Application Request Form, you will receive an application for medical staff appointment and clinical privileges. Please note that these are minimum standards. Each hospital to which you are requesting medical staff appointment, upon receipt of a completed application, will conduct further review of your credentials prior to making a recommendation to its' board of directors.

Sincerely,



Brenda Boblitz, CPMSM
Director, Medical Staff Services

Enclosures

Medical Staff Services
9000 Franklin Square Drive, Baltimore, Maryland 21237-9986
Phone: (443) 777-7410 * Fax: (443) 777-7558

MEDSTAR HEALTH HOSPITALS APPLICATION REQUEST FORM

UPON COMPLETION, PLEASE FAX TO 443-777-7558 OR EMAIL TO BRENDA.BOBLITZ@MEDSTAR.NET

Name: ____ Telephone: _______________

Specialty: ___________________________________ Subspecialty: ______________________

Mailing Address: ____

City: _________________________________ State: ______________ Zip: ______________

Please check the appropriate box. All questions must be answered. Please explain all "no" answers.

1. A Please indicate which of the Baltimore Division MedStar Health hospitals you are seeking appointment.

__________	Franklin Square Hospital Center	__________	Good Samaritan Hospital
__________	Harbor Hospital Center	__________	Union Memorial Hospital

1. B If you currently are on the medical staff of any Baltimore Division MedStar Health hospital, please specify which hospitals. Please also indicate which hospital will be your primary affiliation.

__________	Franklin Square Hospital Center	__________	Good Samaritan Hospital
__________	Harbor Hospital Center	__________	Union Memorial Hospital

2. Are you a MD, DO, DDS, DMD or DPM? Yes ________ No ________

3. Have you had continuous professional liability insurance coverage in the amounts of $1,000,000/$3,000,000? Yes ________ No ________

4. Are you currently licensed by the State of Maryland to practice your profession? Yes ________ No ________

5. Do you have current Federal DEA and Maryland CDS certificates? Yes ________ No ________

6. Do you currently have, or intend to establish, an office within a reasonable distance of the hospital to allow for continuous care of your hospitalized patients? Yes ________ No ________

7. Are you board certified? Yes ________ No ________

8. Will your services be based on a professional service agreement with one or more of the affiliated hospitals? If yes, state hospital(s), title(s) and start date(s). Yes ________ No ________

____

For each hospital indicated in #1.A., please state your plans to utilize that hospital on a separate sheet of paper.

We would also appreciate a copy of your current curriculum vitae which outlines your education and professional background.

I request an application form for medical staff membership and/or clinical privileges. I understand that any misstatement on my part of the above facts will immediately render my request for application void.

_________________________________ _________________________

Applicant's Signature Date